MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 13, 2012
ATTENTION:	Medical Board of California
SUBJECT:	Regulations on Physician Supervision of Licensed Midwives (Business and Professions Code §2507(f).
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

REQUESTED ACTION:

The Midwifery Advisory Council (MAC) has requested the Board to direct staff to set the matter of defining the appropriate level of physician supervision of licensed midwives for regulatory hearing. The proposed regulation is attached.

BACKGROUND:

Business and Professions Code §2507(f) requires the Board to adopt regulations defining the appropriate standard of care and level of supervision required for the practice of midwifery by July 1, 2003. Due to the inability to reach consensus on the supervision issue, the Board bifurcated this requirement and in 2006 adopted Standards of Care for Midwifery (16 CCR, §1379.19). Three previous attempts to resolve the physician supervision issue via legislation and/or regulation have been unsuccessful.

Although required by law, physician supervision is essentially unavailable to licensed midwives as California physicians are generally prohibited in their insurance agreements from providing supervision of midwives who perform home births lest they lose their hospital privileges and insurance coverage. The MAC has previously reported to the Board on the barriers to care the physician supervision requirement creates, such as difficulty securing diagnostic lab accounts, obtaining syringes, IV equipment, oxygen, and necessary injectable medications, etc. California is currently the only state that requires physician supervision of licensed midwives.

On March 31, 2011, the American College of Obstetricians and Gynecologists and the American College of Nurse Midwives issued a joint statement as part of an ongoing initiative to promote collaborative practice between obstetrician-gynecologists and certified nurse-midwives and/or certified midwives.

At the December 13, 2011 MAC meeting, Council members discussed draft language to define the appropriate level of physician supervision of licensed midwives via regulation and voted to request that the Board set the matter for regulatory hearing.

ANALYSIS:

The proposed regulation sets forth a more collaborative approach to the physician supervision issue by providing that the supervision requirement in law is met if the licensee established a

collaborative relationship with a physician who agrees to provide guidance and instructions in the specified circumstances. As is apparent, this is a different approach than saying that a physician has to be on a site at a specified location or available by pager, telephone or other device within a certain time period.

Whenever this issue is discussed, the subjects of liability and insurance (and the cost and availability thereof) always arise. The proposed regulation does provide that a business relationship is not created solely by a physician providing consultative services to or by accepting a referral from a licensed midwife.

A full analysis of possible objections to the proposed regulation is not possible at this time, since both of licensed physicians that were on the MAC had officially resigned prior to the December 13, 2011 MAC meeting. Therefore, Council members and staff did not have input from a licensed physician at the meeting. A California Medical Association representative was present at the meeting; however, she did not provide any public comment. In addition, no one representing the insurance industry was present at the meeting.

FISCAL CONSIDERATIONS

No fiscal impact.

STAFF RECOMMENDATION:

Given the Board's prior unsuccessful attempts to develop regulations on the appropriate level of physician supervision of licensed midwives and the widely divergent opinions of interested parties, staff recommends that the Board consider directing staff to schedule an interested parties meeting to discuss concerns and issues. The issues and concerns brought forth at the meeting could then be summarized and analyzed by staff and brought back to the Board or MAC for further discussion and consideration. To the extent practicable, resolving issues prior to commencing the formal rulemaking process may lead to a more successful effort.

Medical Board of California
Physician Supervision of Midwives
Specific Language of Proposed Changes
Draft—11-29-11

Adopt section 1379.23 in Article 3.5 of Chapter 4 of Division 13, Title 16 Cal.Code Regs. to read as follows:

1379.23. Physician Supervision Requirement.

(a) The requirement for physician supervision contained in Section 2507 of the Code is deemed to have been met if the licensed midwife has established an informal, collaborative relationship with at least one physician who meets the requirements of section 1379.22 and who agrees to provide guidance and instructions regarding the care of women and/or newborns and to provide emergency advice should complications develop.

(b) A physician and surgeon shall not be deemed to have established a business relationship or relationship of agency, employment, partnership, or joint venture with the licensed midwife solely by providing consultation to or accepting a referral from the licensed midwife.

NOTE; Authority cited: Sections 2018 and 2507(f), Business and Professions Code. Reference: Section 2507, Business and Professions Code.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: January 13, 2012
ATTENTION: Medical Board of California
SUBJECT: Midwifery Regulations
STAFF CONTACT: Curtis J. Worden, Chief of Licensing

REQUESTED ACTION:
Direct staff to schedule a public hearing at the May 3-4, 2012 Board meeting to review the adoption of proposed regulation Section 1379.24 in Chapter 24 of Division 13, Title 16 California Code of Regulations authorizing licensed midwives to obtain and administer drugs, immunizing agents, diagnostic tests and devices, and to order laboratory tests, consistent with their educational requirements.

STAFF RECOMMENDATION:
Staff recommends that the Board set for regulatory hearing the adoption of Section 1379.24 in Chapter 24 of Division 13, Title 16 California Code of Regulations, along with any edits or additional provisions that the Board may suggest for inclusion in the regulation.

BACKGROUND:
Current regulations address the educational requirements for midwifery education programs (16 CCR §1379.30). The education program must prepare the midwife for the management of the normal pregnancy, labor, and delivery, including the administration of intravenous fluids, analgesics, postpartum oxytocics, RhoGAM, amniotomy during labor, local anesthesia, paracervical blocks, pudendal blocks, local infiltration, episiotomies, repair of episiotomies and lacerations, administration of vitamin K and eye prophylaxis, and management of routine gynecological care including barrier methods of contraception such as diaphragms and cervical caps. However, current regulations do not specifically authorize a licensed midwife to incorporate these requirements into her practice. As such, midwives often face difficulty in securing supplies such as oxygen, anesthetics, and oxytocics in order to practice safely and effectively.

At the Board's May 6, 2011 meeting, the Midwifery Advisory Council proposed that staff move forward to develop regulations to ensure that midwifery practice and educational requirements are consistent, specifically authorizing licensed midwives to obtain and use the resources they have been educated for. The Board directed staff to work on regulations to ensure consistency.

At the December 13, 2011 Midwifery Advisory Council (MAC) meeting, legal counsel presented language for the proposed regulation. The MAC approved the proposed language with minor edits (attached).

ANALYSIS:
The attached proposed regulation will clarify that licensed midwives have the authority to obtain, order, and administer the drugs, devices, and tests that they have been educated to use in the management of the normal pregnancy, labor, and delivery. In essence, this regulation rectifies

an inconsistency in existing regulations: while midwives are educated to obtain, order, and administer these items, they often cannot acquire them without enormous difficulty.

FISCAL CONSIDERATIONS

No fiscal impact.

MEDICAL BOARD OF CALIFORNIA
Midwifery Program
Specific Language of Proposed Changes
Draft – 12/14/11

Adopt new section 1379.24 in Chapter 4 of Division 13, Title 16 Cal. Code Regs. To read as follows:

1379.24 Practice of Midwifery

A licensed midwife shall have the authority, limited to the practice of midwifery, to obtain and administer drugs, immunizing agents, diagnostic tests and devices, and to order laboratory tests. This authority includes, but is not limited to, obtaining and administering intravenous fluids, analgesics, postpartum oxytocics, RhoGAM, local anesthesia, oxygen, local infiltration, vitamin K, eye prophylaxis, diaphragms and cervical caps.

NOTE: Authority cited: Section 2018, Business and Professions Code.
Reference: Section 2507, Business and Professions Code.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 13, 2012
ATTENTION:	Medical Board of California
SUBJECT:	Composition of the Midwifery Advisory Council
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

BACKGROUND:

Business and Professions Code §2509 (B&P § 2509) directs the Board to create and appoint a Midwifery Advisory Council, consisting of licensees of the Board in good standing and members of the public who have an interest in midwifery practice. At least one half of the Council members are to be licensed midwives. At the February 2007 Board meeting, based on staff's recommendations, the Board appointed obstetrician/gynecologists (licensed physicians) to two of the public member spots and a member of the Board to the other public member spot. The remaining three spots are filled by currently licensed midwives.

It is important to note how the MAC members are actually seated. To fill a vacancy, the MAC calls for applications and then reviews those applications. The MAC, at one of its meetings, then selects an applicant(s) and makes a recommendation to the Board that the applicant be appointed by the Board to the MAC. The Board then considers the recommendation at one of its quarterly meetings. To summarize, the MAC selects and recommends MAC applicants; the Board appoints them.

At the May 6, 2011 Quarterly Board meeting, Karen Ehrlich, LM, former Chair of the Midwifery Advisory Council (MAC) requested that the Board consider modifying the composition of the Council by adding two members (one public member and one licensee, as required by B&P §2509) in order to allow representation by a member of the public who has been the recipient of midwifery services. Ms. Ehrlich reported at the meeting that the midwifery community fells that the voice of parents who have received midwifery care has been missing in discussions and decisions of importance to midwives. The Board authorized the MAC to study the issue of adding members and to return with a recommendation.

In November 2011, two of the public members on the MAC (Ruth Haskins, M.D. and William Frumovitz, M.D.) resigned from their positions, leaving two public member vacancies on the Council. These resignations also leave the MAC without a physician member. Dr. Haskins' term was set to expire in January 2013; Dr. Frumovitz's term was set to expire in July 2012. In addition, one of the licensed midwife member positions will expire in May 2012.

At the December 13, 2011 MAC meeting, the MAC, stated concerns about the need to restore its membership. Rather than requesting that the Board add two additional members to the MAC, Council members voted to recommend the following items to the Board:

1) That one of the vacant public member spots be filled by a non-licensee of the Board and the other vacant public member spot be filled by an obstetrician/gynecologist;
2) That staff expedite a call for applications to the MAC once the Board has approved how to fill the vacancies, so submitted applications could be reviewed at the MAC's March 29, 2012 meeting; and,
3) That the Board delegate its appointing authority in this instance to the MAC to seat the public members at its March 29, 2012 meeting to serve out the remainder of the two vacant terms.

ANALYSIS:

As stated above, the MAC has two public member vacancies and quorum concerns may begin to arise. Additionally, the MAC has traditionally had a least one physician member (usually an obstetrician/gynecologist) and now it has none. There has also been some discussion that perhaps two physicians were too many and that perhaps a parent or other interested party who was not a licensee of the Board in any capacity would bring a different perspective to the MAC.

In order to fill these vacancies, MAC is asking that the Board, delegate its authority to the MAC so that the recommended applicants need not go before the Board to be formally appointed. Rather, at the March 2012 meeting of the MAC, an applicant selected by the MAC would be seated on the MAC.

The issues presented by the MAC's action are twofold: First, does the Board wish to constitute the MAC in the manner suggested (three LMs, one public member who is on the Board, one public member who is not a licensee of the Board, and one obstetrician/gynecologist) versus expanding the overall membership to eight? Second, does the Board wish to delegate its authority to appoint MAC members?

FISCAL CONSIDERATIONS

No fiscal impact.

REQUESTED ACTION:

That the Board take the following actions:

1) Approve the request that the two vacant public member spots be filled by a non-licensee of the Board and the other vacant public member spot be filled by an obstetrician/gynecologist;
2) Direct MBC staff to expedite a call for applications to the MAC so submitted applications could be reviewed at the MAC's March 29, 2012 meeting; and,
3) Delegate its appointing authority in this instance only to the MAC to seat the two public members at its March 29, 2012 meeting to serve out the remainder of the two terms.

STAFF RECOMMENDATION:

An alternative for the Board to consider for item 3 above is that the Board authorize the MAC to appoint members for one meeting only and then consider the MAC recommendations for full appointment at the May 3-4, 2012 Board meeting.

The Board could elect to fill the vacant position that expires in July 2012 to a full three year term, in addition to the remaining time in the current term.